WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Task Force on Medical Malpractice (ATF-MM)

Sample:

Record of Comm. Proceedings ... RCP
- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Appointments* ... *Appt*
- **

- *Clearinghouse Rules* ... *CRule*
- **

- *Committee Hearings* ... *CH*
- **

- *Committee Reports* ... *CR*
- **

- *Executive Sessions* ... *ES*
- **

- *Hearing Records* ... *HR*
- **

- *Miscellaneous* ... *Misc*
- **05hr_ATF-MM_Misc_pt30**

- *Record of Comm. Proceedings* ... *RCP*
- **

AN AUDIT

Patients Compensation Fund

Office of the Commissioner of Insurance

01-11

June 2001

2001-2002 Joint Legislative Audit Committee Members

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June 5, 2001

Senator Gary R. George and
Representative Joseph K. Leibham, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator George and Representative Leibham:

As required by s. 13.94 (1)(de), Wis. Stats., we have completed a financial audit of the Patients Compensation Fund, which insures health care providers in Wisconsin against medical malpractice claims that exceed the primary malpractice insurance thresholds established in statutes. The Fund is governed by a Board of Governors and administered by the Office of the Commissioner of Insurance. In fiscal year 1999-2000, 11,809 health care providers participated in the Fund. We have provided an unqualified auditor's report on the Fund's financial statements for fiscal years ending June 30, 2000, 1999, and 1998.

Past audit reports discussed concerns regarding the Fund's accounting deficit. Action by the Board of Governors and the Legislature and recent favorable claims experience have contributed to a significant improvement in the Fund's financial position, which showed an accounting surplus of $27.2 million as of June 30, 2000. To address concerns being raised about actuarial estimates that affect the Fund's financial position, and to promote broader acceptance of the actuarial analyses and related decisions, we include a recommendation that a comprehensive review of the consulting actuary's methods and assumptions be performed by an independent actuary.

Further, the Fund needs to take additional steps to ensure that all health care providers are obtaining primary insurance coverage as required by statutes. Our testing disclosed several instances in which providers had not obtained the primary malpractice coverage required by statutes. These uninsured providers could be held liable for up to $1 million in settlements or judgements per claim if any malpractice claims were resolved against them.

We appreciate the courtesy and cooperation extended to us by the staff of the Office of the Commissioner of Insurance and the contractors who assist in administering the Patients Compensation Fund program.

Respectfully submitted,

Janice Mueller
State Auditor

JM/DA/ao

Summary

The Patients Compensation Fund was created for the purpose of paying medical malpractice claims that exceed primary insurance thresholds specified in ch. 655, Wis. Stats. The Fund is managed by a Board of Governors, administered by the Office of the Commissioner of Insurance, and financed through assessments on most health care providers and earnings on the Fund's investments.

Section 13.94(1)(de), Wis. Stats., requires the Legislative Audit Bureau to perform financial audits of the Patients Compensation Fund. As necessary parts of this audit, we reviewed the Fund's control procedures; assessed the fair presentation of its financial statements as of and for fiscal years ending June 30, 2000, 1999, and 1998; and reviewed compliance with statutory provisions.

We have provided an unqualified auditor's report on the Patients Compensation Fund's financial statements. We also note that the Fund's financial status has improved in recent years. However, questions regarding the reasonableness of actuarial estimates that have a direct effect on the Fund's financial position suggest that additional steps may be warranted to increase confidence in the Fund's financial operations. In addition, the Fund needs to take extra steps to ensure that all health care providers obtain required primary insurance coverage.

For several years, the Fund reported an accounting deficit, which reached its lowest point at a negative $122.7 million as of June 30, 1988. The accounting deficit reflected the excess of estimated loss liabilities over the cash and investments available to pay them. Loss liabilities are based on actuarial estimates of what the Fund may need to pay for medical malpractice incidents that have already occurred, although they may not yet be settled or even reported. The Board of Governors and the Legislature have taken a number of steps through the years that have contributed toward improving the Fund's financial position and eliminating the accounting deficit. In addition, the Fund's actuary has decreased estimates of loss liabilities over the years, which has also decreased the accounting deficit. As of June 30, 2000, the Fund had an accounting surplus of $27.2 million.

However, in response to adjustments the Fund's actuary has made to past estimates, some interested parties have raised concerns that the actuary may be overly conservative in estimating loss liabilities. For nine of the last ten years, the actuary has reduced its estimate of loss liabilities because of more favorable claim experience than originally expected, especially in comparison to national activity. The Board of Governors' decisions in establishing assessment levels also appear to be affected by the actuary's recent downward adjustments of estimates. The Board has approved assessment levels lower than those recommended by the actuary for eight of the last ten years.

To address concerns being raised about the actuarial estimates and to promote broader acceptance of the actuarial analyses and related decisions, a comprehensive review of the consulting actuary's methods and assumptions by an independent actuary may be warranted. In addition, we suggest that the Office of the Commissioner of Insurance work with the Board to provide actuarial representation on the Board's Actuarial and Underwriting Committee, which initially reviews the actuarial analysis completed for the Fund and advises the Board on actions to take in response to the actuary's analysis and recommendations. Two of the Committees' five current members are physicians, one is a Certified Registered Nurse Anesthetist, and one is a representative of the Wisconsin Hospital Association. The fifth member is an insurance agent. Since the health care provider representatives will be affected directly or indirectly by decisions regarding future assessments, some may argue that there may be an appearance of a conflict of interest. In order to avoid this appearance, a broader array of interests could be represented on the Committee.

Fund staff also need to take steps to ensure that all health care providers are maintaining appropriate primary insurance coverage. Health care providers are required to maintain primary malpractice coverage with an authorized insurer or to qualify as a self-insurer for coverage up to statutorily specified amounts before the Fund's coverage begins. The Fund is required by s. 655.23(7), Wis. Stats., to notify the appropriate licensing board in the Department of Regulation and Licensing when a health care provider does not have the required primary insurance coverage.

To comply with the primary insurance coverage requirements, health care providers may purchase either "occurrence" or "claims-made" insurance. Occurrence policies protect the insured for any incident occurring during the policy's term, regardless of the date reported. Claims-made policies cover only incidents that occur and are reported during the same policy year, and they require a provider to obtain retroactive coverage for incidents that occurred in a prior policy year but are reported in the current year. If a provider terminates claims-made coverage or changes carriers, the provider should purchase an extended reporting endorsement, or "tail" coverage, to insure against incidents that occur during the terms of the policy but are reported after the policy expires. If the provider switches to an occurrence policy with a subsequent carrier, the provider could instead purchase a "prior acts" policy, which closes the coverage gap in a similar manner. A coverage gap will occur with claims-made policies if a provider fails to purchase retroactive, tail, or prior acts policies when needed. During our testing, we found several instances in which health care providers with claims-made insurance did not have required retroactive or tail coverage for periods not covered by the claims-made policies.

In November 2000, a claim was filed for a period in which a provider did not have the appropriate tail coverage. The outcome of this case is yet to be determined; however, the provider is responsible for any claim judgment up to $1 million. Our report recommends that the Fund take immediate steps to identify all providers with insufficient primary coverage and follow up with the providers and the Department of Regulation and Licensing to bring about compliance with state law. We also recommend that the Fund develop routine procedures to formally notify providers and the Department whenever a provider does not have sufficient primary coverage.

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Introduction

The Patients Compensation Fund insures health care providers in Wisconsin against medical malpractice claims that exceed the primary malpractice insurance thresholds established in statutes. It was created in Chapter 37, Laws of 1975 in response to concerns over the cost and availability of medical malpractice insurance. The Fund is managed by the 13-member Board of Governors, which is chaired by the Commissioner of Insurance and also oversees the Wisconsin Health Care Liability Insurance Plan, a public health care liability risk-sharing plan. The Office of the Commissioner of Insurance has statutory responsibility for administering the Fund and contracts with Wausau Insurance Companies for claims administration and the Physicians Insurance Company of Wisconsin, Inc., for risk management services. Since 1978, the actuarial firm of Milliman and Robertson, Inc., has served as a consultant providing actuarial services for the Fund.

Most health care providers in Wisconsin are required to purchase secondary medical malpractice insurance from the Fund.

Statutes require most health care providers that operate or have permanent practices in Wisconsin to maintain primary malpractice coverage of $1 million for each incident, and $3 million per policy year. Most health care providers that permanently operate or practice in Wisconsin are also required to participate in the Fund, which provides unlimited liability coverage for economic damages that exceed the primary limits established in statutes. Health care providers that are insured by the Fund include individuals, such as physicians and nurse anesthetists; institutions such as nursing homes, ambulatory surgery centers, and hospitals; and entities that are owned or controlled by hospitals, as well as entities such as medical partnerships, corporations, and cooperatives.

Assessment rates vary by provider type.

As of June 30, 2000, 11,809 health care providers were assessed $47.9 million for coverage in fiscal year (FY) 1999-2000. Assessment rates vary by provider type and specialty. For example, among individual providers, rates are higher for physicians than for nurses, and higher for physicians who perform surgery than for those who do not. Appendix 1 lists annual assessment rates for various providers from FY 1997-98 through FY 2001-02. Statutes limit the overall level of fees the Board of Governors may assess in any one year. In FY 1999-2000, the limit was set at $80.4 million.

The Fund paid over $476 million for 571 claims from its inception through March 31, 2001.

A medical malpractice claim may be filed years after an incident occurs, and there is no limit on the amount of economic damages the Fund may be required to pay. Coverage for providers is based on participation in the fiscal year in which an event that results in a claim occurred, rather than the fiscal year in which the claim is made. The Fund paid over $476 million in claims from its inception through March 31, 2001, and more than 80 percent of the 571 claims paid have been for amounts less than $1 million. These claims account for 32 percent of total claim payments. In contrast, there have been 15 claims for $5 million or more each. These claims represent over 27 percent of total claim payments.

A small number of large-value claims can significantly affect the Fund's operations and cash flow, but the uncertainty and long-term nature of medical malpractice makes it difficult to predict if or when large claims will be settled and paid from the Fund. For example, the Fund paid an $8.6 million claim in December 1999 for an incident that occurred over 11 years earlier. The variability of annual claim payments is illustrated in Figure 1. As shown, claim payments for the first three quarters of FY 2000-01 are nearly double what they had been in each of the previous three fiscal years, when they were at their lowest point in the past decade.

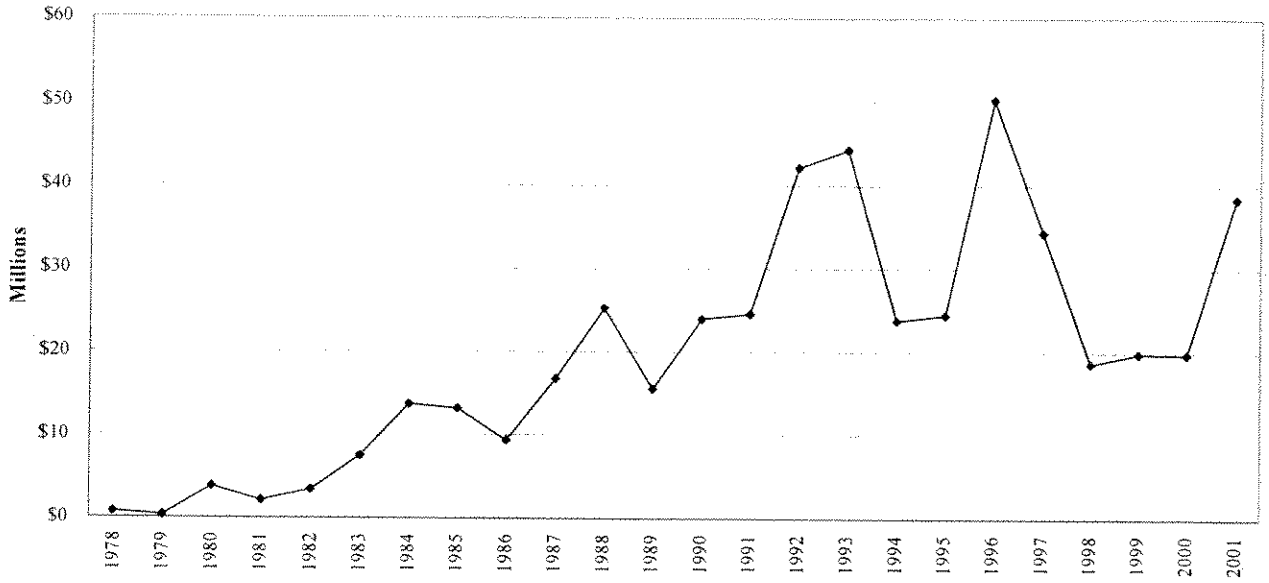
Investment earnings reduce the assessments providers pay for coverage.

Since its creation in 1975, the Fund has typically received more in assessments and investment income than it has paid out in claims and administrative expenses. As a result, its cash and investment balances have grown to over $542 million as of June 30, 2000. Investment income accounts for $275 million of this amount, and more than 27 percent of the Fund's total revenue since 1975. Investment earnings help to reduce the provider assessments that fund current and future claim payments.

By law, the Legislative Audit Bureau is responsible for performing financial audits of the Patients Compensation Fund. As necessary parts of our financial audit, we reviewed the Fund's control procedures, assessed the fair presentation of its financial statements for FYs 1999-2000, 1998-99, and 1997-98, and reviewed compliance with statutory provisions. We also reviewed the financial status of the Fund.

Figure 1

Annual Claim Payments*



* Annual claim payments are shown as of June 30 for all years except 2001, for which they are shown through March 31.

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Although their interests and priorities differ, health care providers, consumers of health care services, and trial lawyers all benefit by having confidence in the reliability and appropriateness of the Fund's financial information and decisions. The Fund's financial status has improved in recent years, but questions regarding the reasonableness of the actuarial estimates used in financial operations suggest a need for the Fund's managers and the Board of Governors to take additional steps to increase confidence in and acceptance of their financial decisions. The Fund's managers should also take additional steps to ensure that all health care providers insured by the Fund have obtained the primary insurance coverage that is required by statutes.

Financial Status of the Fund

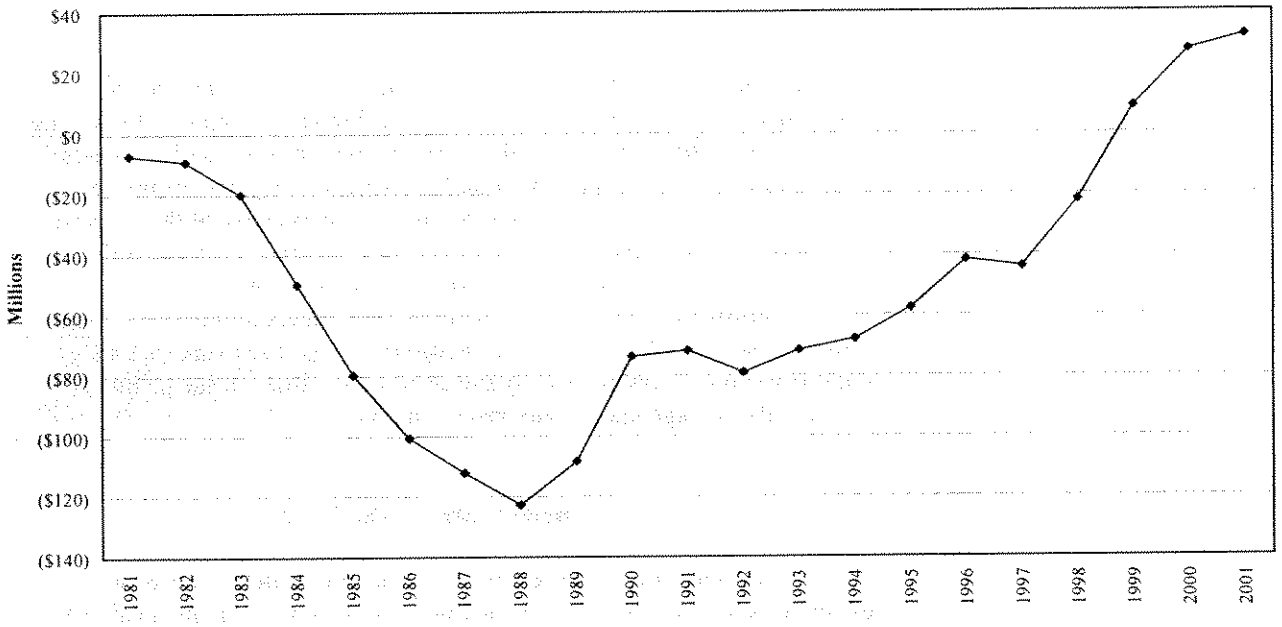
For several years, the Fund reported an accounting deficit because estimated claim liabilities exceeded the cash and investments available to pay them. Claim liabilities are based on estimates of what the Fund may be required to pay for malpractice incidents that have occurred but may not yet have been settled or even reported. The Board of Governors relies on the consulting actuarial firm to estimate the Fund's claim liabilities and to recommend the annual fees health care providers should be assessed for coverage.

The Fund's financial position has improved.

The Fund's accounting deficit, which is largely based on actuarial estimates of liabilities, reached a low of a negative $122.7 million on June 30, 1988. As shown in Figure 2, the Fund's financial position has generally improved since. Beginning in FY 1998-99, the Fund has been reporting an accounting surplus that the consulting actuary projects will increase to $32.0 million by June 30, 2001.

Figure 2

June 30 Accounting Balances*



* Balance for 2001 is projected by Milliman and Robertson, Inc., the Fund's consulting actuary.

A number of actions by the Board and the Legislature have contributed to the Fund's improved financial position. For example:

- Statutory changes in 1990 allowed the State of Wisconsin Investment Board to make long-term investments for the Fund. The Fund's consulting actuary estimates that from September 1990, when the Fund initiated a long-term portfolio, through September 30, 2000, investment returns increased by $76.6 million more than they would have if all assets had continued to be invested in a short-term account. Beginning in 2000, the Board of Governors has authorized the Fund to invest up to 20 percent of its portfolio in equity index funds.

- Legislative action in 1995 re-established a limit on awards for non-economic damages, such as pain and suffering, embarrassment, mental distress, and the loss of companionship and affection. These damage awards had been limited to $1 million from June 14, 1986 through December 31, 1990. The re-established limit was set to begin at $350,000 for medical malpractice incidents that occurred on or after May 25, 1995, and to be adjusted at least annually to reflect changes in the consumer price index. The limit for current non-economic damage awards is $392,871. However, the constitutionality of this limit is being challenged in over 40 court cases. An appeals court recently ruled in one contested case that the limit is constitutional.

- The statutory thresholds at which secondary coverage by the Fund is to begin have been raised as the primary insurance requirement has increased over time. Initially, primary medical malpractice coverage limits were $200,000 for each incident and $600,000 per policy year. As noted, they are currently $1 million for each incident and $3 million per policy year.

- The Board has increased assessment fees in six of the first eight years of the 1990s. From FY 1988-89 to FY 1996-97, assessments for nurse anesthetists and physicians specializing in obstetric or neurological surgery increased by 32.9 percent and 38.8 percent, respectively.

Actuarial Estimates

Some interested parties are concerned that the actuary may be overly conservative in estimating claims, or loss liabilities, and suggest that improvement to the Fund's financial status are related to actuarial adjustments of estimated loss liabilities. Because a medical malpractice claim may be filed years after an incident and there is no limit on the amount of economic losses the Fund may be required to pay, the actuary reviews and revises individual and total loss liability estimates each year, based on subsequent experience and information. For the last ten years, annual adjustments to previously reported total loss liabilities have ranged from an increase of $4.3 million to a decrease of $20.2 million, or from 0.9 percent more than the previously reported loss liabilities balance to 4.0 percent less. Any individual adjustment does not appear to be materially significant, especially considering the

uncertainty surrounding medical malpractice cases. However, in nine of ten years from FY 1990-91 through FY 1999-2000, the actuary's initial estimate of loss liabilities has been decreased following actuarial review of subsequent experience and information.

For 14 consecutive years, the actuary reduced original loss liability estimates in subsequent years.

The aggregate effect of revised actuarial estimates is illustrated in Table 1, which compares the most recent estimate of ultimate losses and legal defense liabilities to the original estimates for each policy year since FY 1981-82. As shown in Table 1, the actuary originally estimated that medical malpractice events that occurred in FY 1986-87 would ultimately result in loss and legal costs to the Fund of $49,021,792. However, the actuary's most recent estimate of the Fund's loss and legal liabilities for medical malpractice events that occurred in FY 1986-87 is $26,965,903, or $22.1 million less than the original estimate. Table 1 also suggests that the actuary underestimated ultimate loss and legal defense liabilities during the Fund's earlier years and has been overestimating them since FY 1986-87.

The Fund's claim experience has been more favorable than the actuary's projections.

The actuary indicates the ultimate loss estimates were reduced because claim experience was more favorable than originally expected, especially compared to claim activity nationally. As was shown in Figure 1, the Fund's claim payments were below $20 million in each year from FY 1997-98 through FY 1999-2000. In contrast, a number of recent medical malpractice cases in other states have resulted in verdicts of more than $30 million, including a $79 million verdict in New York, a $55 million verdict in Illinois, and a $40 million verdict in Texas.

Table 1

Actuarial Revisions to Ultimate Loss Estimates

Policy Year	Original Estimate	Most Recent Estimate*	Increase (Reduction)
FY 1981-82	$ 10,060,000	$ 25,021,513	$14,961,513
FY 1982-83	11,206,000	21,233,963	10,027,963
FY 1983-84	21,849,654	22,152,633	302,979
FY 1984-85	28,067,902	18,121,019	(9,946,883)
FY 1985-86	34,150,248	61,073,330	26,923,082
FY 1986-87	49,021,792	26,965,903	(22,055,889)
FY 1987-88	55,106,186	50,340,995	(4,765,191)
FY 1988-89	56,896,321	42,519,063	(14,377,258)
FY 1989-90	56,402,240	53,770,019	(2,632,221)
FY 1990-91	64,553,518	52,457,771	(12,095,747)
FY 1991-92	74,169,162	65,691,796	(8,477,366)
FY 1992-93	83,375,724	73,896,067	(9,479,657)
FY 1993-94	91,338,273	85,769,438	(5,568,835)
FY 1994-95	91,668,669	89,648,881	(2,019,788)
FY 1995-96	87,341,100	83,126,290	(4,214,810)
FY 1996-97	100,739,270	95,443,379	(5,295,891)
FY 1997-98	83,750,340	79,370,711	(4,379,629)
FY 1998-99	87,917,582	85,060,432	(2,857,150)
FY 1999-00	92,519,004	91,464,945	(1,054,059)
FY 2000-01	98,736,961	98,736,961	0
Total	$1,278,869,946	$1,221,865,109	($57,004,837)

* The most recent estimates are based on the actuary's September 30, 2000 report to the Actuarial and Underwriting Committee, dated January 31, 2001.

As shown in Table 2, the largest claim awards paid from the Fund since its inception have been $18.0 million paid in 1993 for an incident that occurred in 1986, and $15.6 million paid in 1996 for an incident that occurred in 1993. The actuary also believes that recent claim experience has been affected by potential claimants' delays in reporting claims or bringing them to trial until recent challenges to the constitutionality of the limit on non-economic damages have been resolved by the courts.

Table 2

Awards Greater than $5 Million through March 2001

Amount (in millions)*	Calendar Year of Incident	Calendar Year of Payment	Claimant Allegations
$18.0	1986	1993	Diet pills prescribed without a complete physical evaluation, causing cardiac arrest and resulting in brain damage
15.6	1993	1996	Negligent treatment caused quadriplegia
13.6	1993	2000	Initial surgery and follow-up treatment of pinched nerve were negligent, causing continuing pain
9.5	1989	1990	Improperly administered anesthesia caused brain damage during cardiac surgery
9.2	1991	1994	Overdose of morphine to infant caused cardiac and respiratory arrest and brain damage
8.6	1988	1999	Negligent treatment caused brain damage, and lack of informed consent
7.9	1985	1995	Failure to diagnose a hematoma caused brain damage, and lack of informed consent
7.3	1987	1992	Failure to identify high bilirubin level in a timely manner, resulting in brain damage
7.1	1990	1995	Failure to promptly deliver baby, causing cerebral palsy
6.9	1992	2000	Negligent delivery caused brain damage
6.8	1992	1995	Negligent treatment of brain aneurysm
5.8	1990	1996	Surgery caused brain injury, and lack of informed consent
5.6	1995	1998	Negligent treatment caused brain damage
5.6	1993	1999	Negligent treatment caused brain damage
5.1	1982	1984	Failure to diagnose and treat meningitis

* Includes interest on losses paid.

The reasonableness and acceptance of the actuarial estimates are important not only for financial reporting, but also in the assessment-setting process. As part of an annual process, the actuary estimates and recommends changes in assessment levels needed for the next fiscal period. Typically, the recommended assessment changes are based on the actuary's estimate of assessment levels required to fund claims for

incidents that will occur during that period, with adjustments for any existing deficit or surplus.

The Board has approved assessment rates lower than those recommended by the actuary.

The Board of Governors has consistently accepted the actuary's estimates for loss liabilities. However, as shown in Table 3, the Board has approved assessment levels lower than those recommended by the actuary in all but two policy years since FY 1992-93. For the FY 2001-02 assessments, the actuary provided a range of assessment changes based on different scenarios for eliminating the accounting surplus, and the Board approved a rate within the range offered. A noteworthy difference between the actuary's recommendation and the change approved by the Board occurred in FY 2000-01, when the actuary recommended a 3.7 percent increase and the Board approved a 25 percent decrease in total assessments. The Board's decision appeared to be affected, in part, by the actuary's adjustments to past loss estimates. In addition, the Board noted that the Fund's large investment balance and the accounting surplus would provide flexibility to respond to unfavorable experience in the future by increasing rates.

Table 3

Annual Percentage Changes to Assessment Fees

Policy Year	Percentage Change Recommended by Actuary	Percentage Change Approved by Board	Actual Assessments
FY 1992-93	13.2%	4.0%	$45,063,934
FY 1993-94	16.8	10.0	51,213,220
FY 1994-95	10.8	7.1	55,505,730
FY 1995-96	4.9	(11.2)[1]	51,048,881
FY 1996-97	17.3	10.0	58,259,200
FY 1997-98	(17.7)[2]	(17.7)[2]	49,884,839
FY 1998-99	5.9	0.0	50,621,706
FY 1999-00	2.7	(7.0)	47,879,282
FY 2000-01	3.7	(25.0)	35,909,462[4]
FY 2001-02	(28.6) to 28.2[3]	(20.0)	28,727,569[4]

[1] Adoption of limit on non-economic damages affected the change approved.
[2] Fees were reduced because the Fund's threshold increased from $400,000/$1 million to $1million/$3million.
[3] The actuary provided four rate recommendations ranging from a decrease of 28.6 percent to an increase of 28.2 percent based on four different scenarios for eliminating the surplus.
[4] Projected based on FY 1999-00 assessments, adjusted for changes approved by the Board.

An independent review of the actuary's methods and assumptions may be warranted.

In light of questions being raised about the actuarial estimates and the practice of implementing lower assessment levels than recommended by the actuary, an independent review or audit of the actuary's analysis may be warranted. Based on our review of the actuary's analysis as part of our financial audit of the Fund, we believe that the analysis provides a reasonable basis for estimating and reporting claim liabilities in the Fund's financial statements. However, a more comprehensive review of the actuary's methods and assumptions by an independent actuary could provide suggestions to the consulting actuary for refining its analysis and may be useful in promoting broader acceptance of the actuarial analyses by the various interested parties.

Actuarial audits are becoming fairly common for critical actuarial analyses and are considered useful and effective oversight mechanisms. For example, an independent audit of the actuarial analysis for the Wisconsin Retirement System is performed every five years. An actuarial audit may be especially useful for the Fund because of the long-term nature of the medical malpractice environment, increased unpredictability resulting from the Fund's unlimited coverage, and the significant effect actuarial analyses have on the Fund's financial decisions and operations. Because the Fund is smaller and less complex than the Wisconsin Retirement System, any actuarial audit for the Fund can be expected to cost less than the actuarial audit for the Wisconsin Retirement System, which is approximately $45,000. *We recommend the Office of the Commissioner of Insurance contract for an audit of the actuarial methods and assumptions used in estimating claim liabilities and recommending assessment levels for the Patients Compensation Fund.*

Steps could also be taken to promote increased understanding and acceptance of actuarial estimates and their use among members of the Fund's Board of Governors and representatives to its various committees. Statutes provide for the following representation on the Board of Governors:

- three representatives from the insurance industry, who are appointed by the Commissioner of Insurance;
- one member appointed by the State Bar;
- one member appointed by the Wisconsin Academy of Trial Lawyers;
- two members appointed by the Wisconsin Medical Society;

- one member appointed by the Wisconsin Hospital Association;

- the Commissioner of Insurance or designee from the Office; and

- four public members appointed by the Governor, two of whom cannot be attorneys or physicians or be affiliated with a hospital or an insurance company.

The Board has established various committees to assist in its oversight of the Fund and the Wisconsin Health Care Liability Insurance Plan. Some committee members are members of the Board, and others have been selected for their interest or willingness to serve.

The Board's Actuarial and Underwriting Committee reviews the actuarial analysis completed for the Fund and advises the full Board on actions to take in response to the actuary's analysis and recommendations. Two of its five current members are members of the Board. However, neither the Board nor the Actuarial and Underwriting Committee currently includes a member with actuarial background. For several years, an actuary who served on the Board as one of the insurance industry representatives also chaired the Actuarial and Underwriting Committee. However, this individual left the Board in July 2000, and the position on the Board, which is appointed by the Commissioner of Insurance, has remained vacant since the actuary's departure.

Besides lacking a representative with an actuarial background, the current Actuarial and Underwriting Committee consists primarily of health care provider representatives. Two of its five current members are physicians, one is a Certified Registered Nurse Anesthetist, and one is a representative of the Wisconsin Hospital Association. The fifth member is an insurance agent. Since the health care provider representatives will be affected directly or indirectly by decisions regarding future assessments, some may argue that there may be an appearance of a conflict of interest. To avoid this appearance, a broader array of interests could be represented on the Committee.

Therefore, *we recommend the Office of the Commissioner of Insurance appoint an actuary to the vacant insurance representative position on the Board of Governors and work with the Board to provide actuarial representation on the Actuarial and Underwriting Committee. Further, we recommend that membership on the Actuarial and Underwriting Committee be broadened to represent interests in addition to those of health care providers.*

Section Ins 17.25(8), Wis. Adm. Code, grants the Board power to appoint advisory committees of interested persons to advise it as needed but does not prescribe the minimum participation requirements for these committees. The Board may wish to consider establishing formal guidelines for membership requirements for each of its primary committees to ensure the interests of the Fund are best represented.

Noncompliance with Primary Insurance Coverage Requirements

Statutes require health care providers to purchase either "occurrence" or "claims-made" insurance to meet primary insurance requirements. Occurrence policies cover the insured for any incident occurring during the policy's term, regardless of the date reported. Claims-made policies protect only against incidents that occur and are reported during the same policy year. During our testing, we found that the Fund does not have adequate procedures in place to ensure that health care providers who have or had claims-made insurance maintain appropriate coverage.

A provider maintaining an annual claims-made policy must also obtain retroactive coverage to cover incidents that occurred in a prior policy year but are reported during the current year. If a provider terminates claims-made coverage or changes insurance carriers, an extended reporting endorsement, or "tail" coverage, can be purchased to insure against incidents that occurred during the policy term but are reported after the policy expires. If the provider switches to an occurrence policy with a subsequent carrier, a "prior acts" policy can be purchased to close the coverage gap in a similar manner.

If a provider fails to purchase retroactive, tail, or prior acts policies when needed, coverage gaps will occur under claims-made policies. In an effort to prevent such gaps, Wisconsin Administrative Code requires all claims-made policies to contain prominent notices to inform providers of their obligations. One notice indicates that the insured is obligated to purchase an extended reporting endorsement with the insurer unless other insurance is available to ensure continuing coverage for the term the policy is in effect. Another notice states that the insurer will notify the Commissioner of Insurance if the provider does not purchase the extended reporting endorsement and that the provider may be subject to administrative action by his or her licensing board in the Department of Regulation and Licensing. Section 655.23(7), Wis. Stats., requires the Fund to notify the appropriate licensing board when a health care provider has not obtained proper coverage. The licensing board may suspend or refuse to issue or to renew the license of any health care provider in violation of the rules.

The Fund appears to receive the required notification from primary insurance carriers when providers have not purchased the appropriate coverage. This information is recorded in a computerized system.

However, the Fund does not take steps to ensure that these providers have obtained alternative coverage, and it does not have procedures in place to notify providers and, when applicable, the appropriate licensing board within the Department of Regulation and Licensing when providers have not obtained proper primary medical malpractice insurance coverage and therefore are not in compliance with statutory requirements.

When we reviewed the Fund's computerized system, 2 of the 36 providers selected for review did not have the proper tail or prior acts coverage from their primary insurer. We then tested 30 more providers from a population of 978 providers having at least one noncompliance entry for no-tail coverage on their system records. Five of these 30 providers (16.7 percent) did not have the proper tail or prior acts coverage as of our test date. The others had purchased the proper coverage from different carriers. If the same proportion of noncompliant providers were present among the remaining 948 providers having at least one entry for no-tail coverage, more than 150 additional providers could be noncompliant and have gaps in their coverage.

Because the Fund is not informing the Department of Regulation and Licensing when providers have not obtained appropriate tail or prior acts coverage, the Department of Regulation and Licensing does not have the knowledge or opportunity to apply penalties, such as suspension or non-renewal of these providers' licenses. In addition, if a claim were brought against a provider for an incident that occurred during a coverage gap, the provider rather than the provider's insurance company would be liable for any portion of a settlement or judgement resulting from that claim.

In November 2000, a claim was filed for a period in which the provider did not have the appropriate tail coverage. While the outcome of this case is yet to be determined, the provider is now responsible for up to $1 million of any claim judgment that results from this case. The primary insurer had previously notified this provider of the insufficient coverage, but the Fund's staff had not notified the Department of Regulation and Licensing or the provider of this noncompliance. Had the Department of Regulation and Licensing been notified, it is possible that the provider may have been prompted to obtain the required coverage. According to the Fund's staff, this is the first instance of a claim being filed against a provider without appropriate coverage when neither the provider nor the Department of Regulation and Licensing had been notified because of insufficient procedures.

To ensure all providers are obtaining the appropriate primary coverage and that the Fund is in compliance with s. 655.23(7), Wis. Stats., *we recommend the Patients Compensation Fund take immediate steps to identify all providers that currently have insufficient coverage and follow up with providers and the Department of Regulation and*

Licensing to bring about compliance with state law. Further, we recommend Patients Compensation Fund staff develop and implement routine procedures to formally notify providers and the Department of Regulation and Licensing whenever a provider does not have sufficient primary coverage.

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Independent Auditor's Report on the Financial Statements of the Patients Compensation Fund

We have audited the accompanying balance sheet of the State of Wisconsin Patients Compensation Fund as of June 30, 2000, 1999, and 1998, and the related statement of revenues, expenses, and changes in retained earnings and statement of cash flows for the years then ended. These financial statements are the responsibility of the management of the Patients Compensation Fund. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As described in Note 1, the financial statements present only the Patients Compensation Fund and are not intended to present fairly the financial position of the State of Wisconsin and the results of its operations and changes in financial position of its proprietary and trust fund types in conformity with accounting principles generally accepted in the United States.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Patients Compensation Fund as of June 30, 2000, 1999, and 1998, and the results of its operations and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States.

As discussed in Note 4 to the financial statements, the Patients Compensation Fund's projected ultimate loss liability is based on recommendations of a consulting actuary. The ultimate loss liability includes estimates for reported losses and estimates for losses that have been incurred but not reported. The management of the Patients Compensation Fund believes that the estimated loss liability is reasonable and adequate to cover the cost of claims incurred to date. However, the ultimate losses incurred are difficult to estimate because of the nature of unlimited excess liability coverage provided. Because of the uncertainties, the amount that will ultimately be paid to settle these liabilities may vary significantly from the estimated amounts included in the accompanying balance sheet.

In accordance with *Government Auditing Standards*, we also issue a report dated May 18, 2001, on our consideration of the Patients Compensation Fund's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

LEGISLATIVE AUDIT BUREAU

May 18, 2001

by

Diann Allsen
Audit Director

State of Wisconsin
Office of the Commisioner of Insurance
Patients Compensation Fund
Balance Sheet
June 30, 2000, 1999, and 1998

	June 30, 2000	June 30, 1999	June 30, 1998
Assets			
Cash and Cash Equivalents (Note 3)	$ 16,221,473	$ 6,146,443	$ 10,499,113
Investment Income Receivable	9,665,272	8,986,671	7,007,673
Assessments Receivable	311,767	435,123	325,077
Other Receivables	11,855	12,066	10,970
Investments (Note 3)	516,370,104	485,510,585	444,364,302
Supplies Inventory and Other Assets	4,024	3,990	3,559
Fixed Assets, Net of Accumulated Depreciation	28,540	39,337	16,838
Total Assets	$ 542,613,035	$ 501,134,215	$ 462,227,532
Liabilities and Retained Earnings			
Loss Liabilities (Note 4):			
Incurred but not reported losses	$ 670,816,786	$ 634,019,829	$ 598,988,648
Reported losses	46,463,285	28,251,924	14,712,132
Loss adjustment expense	31,381,540	30,846,563	25,029,838
Estimated loss liabilities	748,661,611	693,118,316	638,730,618
Amount representing interest	(235,079,746)	(205,163,022)	(158,452,190)
Discounted loss liabilities	513,581,865	487,955,294	480,278,428
Liabilities for future medical expenses (Note 5)	143,179	135,991	154,404
Contributions being held (Note 6)	400,000	400,000	400,000
Total Loss Liabilities	514,125,044	488,491,285	480,832,832
Other Liabilities:			
Assessments received in advance (Note 2)	472,728	2,892,201	2,928,446
Provider refunds payable	514,092	1,011,424	449,205
General and adminstrative expense payable	149,343	108,344	166,702
Medical mediation panel payable (Note 7)	2,148	12,661	6,949
Vouchers payable	100,000	30,202	0
Compensated absences	19,970	8,330	10,129
Total Liabilities	515,383,325	492,554,447	484,394,263
Retained Earnings	27,229,710	8,579,768	(22,166,731)
Total Liabilities and Retained Earnings	$ 542,613,035	$ 501,134,215	$ 462,227,532

The accompanying notes are an integral part of this statement.

State of Wisconsin
Office of the Commissioner of Insurance
Patients Compensation Fund
Statement of Revenues, Expenses, and Changes in Retained Earnings
for the Years Ended June 30, 2000, 1999, and 1998

	For Year Ended June 30, 2000	For Year Ended June 30, 1999	For Year Ended June 30, 1998
Operating Revenues			
Assessments (Note 2)	$ 47,879,282	$ 50,621,706	$ 49,884,839
Investment Income	19,937,967	10,899,966	50,234,211
Assessment Interest Income (Note 8)	389,990	406,541	239,480
Administrative Fee Income	41,821	39,909	36,303
Other Income	17,272	52,737	108,553
Total Operating Revenues	68,266,332	62,020,859	100,503,386
Operating Expenses			
Underwriting Expenses:			
Net losses paid	19,757,183	19,903,927	23,717,074
Recovery of previous losses paid and interest (Note 9)	0	0	(5,002,872)
Loss adjustment expenses paid	3,204,682	2,695,094	3,844,185
Risk management expenses	98,428	111,016	72,484
Medical expenses paid	0	26,051	4,255
Change in liability for incurred but not reported losses	36,796,957	35,031,181	43,554,961
Change in liability for reported losses	18,211,361	13,539,792	(3,257,345)
Change in liability for loss adjustment expense	534,976	5,816,726	3,802,928
Change in amount representing interest	(29,916,724)	(46,710,832)	16,622,767
Change in liability for future medical expense	7,188	(18,413)	3,868
Total Underwriting Expenses	48,694,051	30,394,542	83,362,305
General and Administrative Expenses	911,541	872,116	901,361
Depreciation Expense	6,040	6,256	15,207
Total Operating Expenses	49,611,632	31,272,914	84,278,873
Net Operating Income (Loss)	18,654,700	30,747,945	16,224,513
Non-Operating Revenues and Expenses			
Loss on Disposal of Fixed Assets	(4,758)	(1,446)	(4,569)
Net Income (Loss)	18,649,942	30,746,499	16,219,944
Retained Earnings			
Beginning Retained Earnings, as Previously Reported	8,579,768	(22,166,731)	(44,094,214)
Prior-Period Adjustment (Note 14)	0	0	5,707,539
Beginning Retained Earnings, as Restated	8,579,768	(22,166,731)	(38,386,675)
Retained Earnings, End of Year	$ 27,229,710	$ 8,579,768	$ (22,166,731)

The accompanying notes are an integral part of this statement.

State of Wisconsin
Office of the Commisioner of Insurance
Patients Compensation Fund
Statement of Cash Flows
for the Years Ended June 30, 2000, 1999, and 1998

	For Year Ended June 30, 2000	For Year Ended June 30, 1999	For Year Ended June 30, 1998
Cash Flows from Operating Activities			
Cash Received from:			
Assessments	$ 48,052,982	$ 51,848,554	$ 57,159,568
Primary malpractice insurers (Note 9)	983,194	743,708	5,973,213
Other operating activity	598,135	681,095	691,410
Cash Payments for:			
Losses	(20,640,377)	(20,647,635)	(24,687,415)
Loss adjustment expenses	(3,204,682)	(2,695,094)	(3,844,185)
Other expenses	(955,195)	(1,059,571)	(866,810)
Provider refunds for fund fees	(2,966,875)	(811,226)	(4,544,900)
Panel fees	(160,133)	(175,595)	(310,788)
Net Cash Provided by Operating Activities	21,707,049	27,884,236	29,570,093
Cash Flows from Capital and Related Financing Activities			
Payments for Purchase of Fixed Assets	(30,202)	0	0
Cash Flows from Investing Activities			
Purchase of Investment Securities	(171,639,942)	(69,993,940)	(54,491,701)
Interest on Investments	31,168,930	33,622,509	27,490,444
Proceeds from Sales of Investments	128,892,193	3,999,252	149,684
Increase (Decrease) in Market Value of Short-term Investments	(22,998)	135,273	(168,798)
Net Cash Used for Investment Activities	(11,601,817)	(32,236,906)	(27,020,371)
Net Increase (Decrease) in Cash and Cash Equivalents	10,075,030	(4,352,670)	2,549,722
Cash and Cash Equivalents at the Beginning of the Year	6,146,443	10,499,113	7,949,391
Cash and Cash Equivalents at the End of the Year	$ 16,221,473	$ 6,146,443	$ 10,499,113
Reconciliation of Net Operating Income to Net Cash Provided by Operating Activities			
Net Operating Income (Loss)	$ 18,654,700	$ 30,747,945	$ 16,224,513
Adjustments to Reconcile Net Operating Income to Net Cash Provided by Operating Activities:			
Depreciation expense	6,040	6,256	15,207
Operating income (investment income) classified as an investing activity	(19,937,967)	(10,899,966)	(50,234,211)
Payments and adjustments to fixed assets classified as capital activity	30,202	(30,202)	4,354
Other adjustments	1,664	11,592	(13,254)
Changes to Assets and Liabilities:			
Decrease (increase) in assessments receivable	123,356	(110,046)	106,771
Decrease (increase) in other receivables	211	(1,096)	(1,321)
Decrease (increase) in supplies inventory and other assets	(35)	(431)	(1,340)
Increase (decrease) in loss liabilities	25,633,759	7,658,453	60,689,781
Increase (decrease) in other liabilities	(2,804,881)	501,731	2,779,593
Total Adjustments	3,052,349	(2,863,709)	13,345,580
Net Cash and Cash Equivalents Provided (Used) by Operating Activities	$ 21,707,049	$ 27,884,236	$ 29,570,093
Noncash Investing, Capital, and Financing Activities:			
Bond Amortization and Net Change in Unrealized Gains and Losses	(14,883,710)	(21,045,189)	21,817,283

The accompanying notes are an integral part of this statement.

1. Description of the Fund

The Patients Compensation Fund, which is part of the State of Wisconsin financial reporting entity, was created in 1975 for the purpose of paying that portion of a medical malpractice claim exceeding the legal primary insurance limits prescribed in s. 655.23(4), Wis. Stats., or the maximum liability limit for which the health care provider is insured, whichever limit is greater. Most health care providers permanently practicing or operating in the State of Wisconsin are required to pay annual assessments.

Management of the Fund is vested with the 13-member Board of Governors, which is chaired by the Commissioner of Insurance. The Board has designated the Commissioner of Insurance as the administrator of the Fund. Similarly, under s. 655.27(2), Wis. Stats., the Commissioner shall either provide staff services necessary for the operation of the Fund or, with the approval of the Board, contract for all or part of these services. During FYs 1999-2000, 1998-99, and 1997-98, the Board contracted for the Fund's actuarial, claim, and risk management services.

2. Summary of Significant Accounting Policies

A. Basis of Presentation - The accompanying financial statements have been prepared in conformity with generally accepted accounting principles (GAAP) in the United States for governments as prescribed by the Governmental Accounting Standards Board (GASB).

B. Basis of Accounting - The accompanying financial statements were prepared based upon the flow of economic resources measurement focus and a full accrual basis of accounting. Under the accrual basis of accounting, revenues are recorded when earned and expenses are recorded at the time liabilities are incurred. Financial Accounting Standards Board (FASB) statements effective after November 30, 1989, are not applied in accounting for the operations of the Fund.

C. Accounting Estimates - The preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results differ from those estimates. Estimates that are particularly susceptible to significant change in future years are the liabilities for unpaid losses and loss adjustment expenses. In estimating these liabilities, management used the methodology discussed in Note 4 on ultimate and discounted loss liabilities.

D. Cash and Cash Equivalents - Cash and cash equivalents reported on the balance sheet and the statement of cash flows include cash deposited with the State of Wisconsin Treasurer, where available balances beyond immediate needs are pooled in the State Investment Fund for short-term investment purposes. The State Investment Fund is a short-term pool of State and local funds managed by the State of Wisconsin Investment Board with oversight by its Board of Trustees. Balances pooled are restricted to legally stipulated investments. The State Investment Fund is not registered with the Securities Exchange Commission as an investment company.

Pool shares of the State Investment Fund are bought and redeemed at $1.00 based on the amortized cost of the investments in the Fund. Income calculations are based on amortized cost of average pool balances. Shares in the State Investment Fund are reported at fair value consistent with the provisions of GASB Statement No. 31, *Accounting and Financial Reporting for Investments and for External Investment Pools*.

E. Investment Valuation - Investments of the Fund consist of high-grade fixed-income securities managed by the State of Wisconsin Investment Board and shares in an equity index fund. Fixed-income obligations and index fund shares are reported at fair value consistent with the provisions of GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*. When available, fair value information is determined using quoted market prices. However, when quoted market prices for certain securities are not available, fair values are estimated.

F. Assessments - Assessments are billed and recognized as revenues on a fiscal-year basis, which is also the policy year. Assessments received for the upcoming fiscal year are treated as deferred revenue and recorded as assessments received in advance. Accounts of providers are automatically credited and reported as refunds payable when primary insurance lapses.

G. Loss Liabilities - Loss liabilities are estimated based on recommendations of a consulting actuary and are discounted to the extent that they are matched by cash and invested assets. The uncertainties inherent in projecting the frequency and severity of claims because of the Fund's unlimited liability coverage and extended reporting and settlement periods make it likely that the amounts ultimately paid will differ from the recorded estimated liabilities.

H. Policy Acquisition Costs - Since the Fund has no marketing staff and incurs no sales commissions, acquisition costs are minimal and charged to operations as incurred.

I. Fixed Assets - The Fund capitalizes all office furniture and equipment with a useful life of two or more years and a purchase price of $5,000 or more. Fixed assets are depreciated under the straight-line method over the estimated useful lives of the assets. Accumulated depreciation as of June 30, 2000, 1999, and 1998, was $45,445, $82,224, and $83,907, respectively.

J. Employee Compensated Absences - Unused, earned compensated absences, other than accumulated sick leave, are accrued with a resulting liability. The liability and expense for compensated absences are based on current rates of pay.

3. Deposits and Investments

A. Deposits - All cash is deposited with the State of Wisconsin Treasurer and is invested by the State of Wisconsin Investment Board through the State Investment Fund. Sections 25.17(3)(b), (ba), and (bd), Wis. Stats., enumerate the various types of securities in which the State Investment Fund may invest and include direct obligations of the United States and Canada, securities guaranteed by the United States, securities of federally chartered corporations, unsecured notes of financial and industrial issuers, Yankee/Eurodollar issues, certificates of deposit issued by banks in the United States and solvent financial institutions in the state, and bankers acceptances. The Board of Trustees of the State of Wisconsin Investment Board may approve other prudent investments. The Board of Trustees has given standing authority to the Investment Board to invest in resale agreements, financial futures contracts, options, and interest rate swaps on behalf of the State Investment Fund.

The fair value of shares in the State Investment Fund was $16,080,823 (net of negative mark-to-market of $56,523) as of June 30, 2000; $5,857,766 (net of negative mark-to-market of $33,525) as of June 30, 1999; and $10,305,221 (net of negative mark-to-market of $168,798) as of June 30, 1998. Shares in the State Investment Fund are not required to be categorized by risk level under GASB Statement No. 3.

B. Investments - As directed by s. 25.17(1)(kp), Wis. Stats., all of the Patients Compensation Fund's investments also are managed by the Investment Board, whose objectives are to invest moneys held in the Fund in investments with maturities and liquidity that are appropriate for the needs of the Fund. Permitted classes of investments include bonds of governmental units or of private corporations, loans secured by mortgages, preferred or common stock, real property, and other investments not specifically prohibited by statute. In FY 1999-2000, SWIB began investing a portion of the Fund's portfolio in equity index funds. The Fund's current investment guidelines limit equity investments to 20 percent of total assets.

All the Fund's fixed income investments required to be categorized by GASB Statement No. 3 meet the criteria for risk category 1. Investments in risk category 1 are insured or registered, or are held by the State or its agent in the State's name. Shares in the equity index fund are not required to be categorized. The amortized cost and fair values of the Fund's investments at year-end are as follows:

	June 30, 2000		June 30, 1999		June 30, 1998	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
Fixed Income Obligations:						
Government & Agency	$154,928,374	$159,986,025	$152,450,125	$159,901,615	$151,640,029	$164,312,147
Industrial	213,569,884	202,136,236	219,589,936	217,357,239	169,500,750	179,336,691
Transportation	7,394,836	7,449,929	9,843,099	10,236,650	9,795,535	10,455,775
Finance	38,038,950	37,742,930	54,920,373	56,001,231	58,880,020	61,535,219
Utilities	64,837,720	60,033,296	38,835,689	36,904,450	22,766,316	23,404,220
Sovereign	4,918,319	4,899,117	4,907,904	5,109,400	4,898,214	5,320,250
Subtotal	483,688,083	472,247,533	480,547,126	485,510,585	417,480,864	444,364,302
Russell 3000 Index Fund	43,577,793	44,122,571	0	0	0	0
Total	$527,265,876	$516,370,104	$480,547,126	$485,510,585	$417,480,864	$444,364,302

4. Ultimate and Discounted Loss Liabilities

A. Loss Liabilities - Loss liabilities include individual case estimates for reported losses and estimates for losses that have been incurred but not reported (IBNR) based upon the projected ultimate losses recommended by a consulting actuary. Individual case estimates of the liability for reported losses and net losses paid from inception of the Fund are deducted from the projected ultimate loss liabilities to determine the liability for IBNR losses as follows:

	June 30, 2000	June 30, 1999	June 30, 1998
Projected ultimate loss liability	$1,160,384,576	$1,085,591,409	$1,017,061,128
Less:			
Net loss paid from inception	(443,104,505)	(423,319,656)	(403,360,348)
Liability for reported losses	(46,463,285)	(28,251,924)	(14,712,132)
Liability for IBNR losses	$ 670,816,786	$ 634,019,829	$ 598,988,648

Loss liabilities also include a provision for the estimated future payment of costs to settle claims. These ultimate loss-adjustment expenses (LAE) as of June 30, 2000, and June 30, 1999, are estimated at 5.0 percent and as of June 30, 1998, are estimated at 4.5 percent of the projected ultimate loss liabilities. The LAE paid from inception of the Fund are deducted from the projected ultimate LAE provision to determine the liability for LAE as follows:

	June 30, 2000	June 30, 1999	June 30, 1998
Projected ultimate LAE liability	$58,019,229	$54,279,570	$45,767,751
Less:			
Net LAE paid from inception	(26,637,689)	(23,433,007)	(20,737,913)
Liability for LAE	$31,381,540	$30,846,563	$25,029,838

B. Re-estimated Loss Liabilities - The loss liability and liability for LAE are continually reviewed as adjustments to these liabilities become necessary. Such adjustments are reflected in current operations. As of June 30, 2000, the actuary estimated that the liabilities for losses and LAE through June 30, 1999, would be $14.0 million (2.0 percent) less than the amount estimated for this period as of June 30, 1999. In a similar fashion, the total losses as of June 30, 1998 and 1997, were estimated one year later to be $10.4 million (1.6 percent) less and $10.2 million (1.7 percent) less, respectively, than originally estimated.

C. Discounted Loss Liabilities - Section Ins 17.27(3), Wis. Adm. Code, requires the liability for reported losses, liability for IBNR losses, and liability for LAE be maintained on a present-value basis, with the difference from full value being reported as a contra account to the loss

reserve liabilities. The loss liabilities are discounted only to the extent that they are matched by cash and invested assets. However, beginning with FY 1998-99, the Fund has held sufficient cash and invested assets to fully match the discounted loss liabilities. If all loss liabilities were discounted, the discounted loss liability would be as follows:

	June 30, 2000	June 30, 1999	June 30, 1998
Estimated unpaid loss liabilities	$717,280,071	$662,271,753	$613,700,780
Estimated unpaid LAE	31,381,540	30,846,563	25,029,838
Total estimated loss liabilities	748,661,611	693,118,316	638,730,618
Less: Amount representing interest	(235,079,746)	(205,163,022)	(164,153,769)
Discounted loss liabilities	$513,581,865	$487,955,294	$474,576,849

The actuarially determined discount factor, on an amortized value basis, was 7.0 percent for FY 1999-2000, 7.0 percent for FY 1998-99, and 7.1 percent for FY 1997-98.

5. Future Medical Expense Liability

Section 655.015, Wis. Stats., requires accounts to be established for future medical expense awards in excess of $25,000 that were entered into or rendered before June 14, 1986, or in excess of $100,000 that were entered into or rendered on or after May 25, 1995.

6. Contributions Being Held Liability

A primary insurer may voluntarily present a nonrefundable payment to the Fund generally equal to the amount of primary coverage in effect for the related claim. This payment from the primary insurer is negotiable with the Fund in exchange for a release of payment for any future defense costs that may be incurred on the claim.

7. Medical Mediation Panel

Section Ins 17.27(3), Wis. Adm. Code, requires the fees collected for administration of the Medical Mediation Panel to be included in the Fund's financial reports, but that they should not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims. The Fund collected

$160,133 in fees in FY 1999-2000, $175,595 in FY 1998-99, and $310,788 in FY 1997-98.

8. Assessment Interest Income

Fund participants choosing payment plans other than annually are assessed interest on the deferred assessment amounts. Section Ins 17.28(4), Wis. Adm. Code, prescribes the interest rate to be assessed on the deferred assessments as the average annualized rate earned by the Fund on its short-term funds for the first three quarters of the preceding fiscal year, as determined by the Investment Board. Interest was assessed at the rate of 4.964 percent for FY 1999-2000, 5.336 percent for FY 1998-99, and 5.201 percent for FY 1997-98.

9. Lawsuit

In March 1994, the Fund filed suit against St. Mary's Hospital of Milwaukee seeking to recover over $3 million, plus interest, that the Fund paid on behalf of St. Mary's with respect to medical malpractice claims. It is the Fund's position that at the time of the payments, St. Mary's was not in compliance with statutory insurance requirements of s. 655.23, Wis. Stats., and was therefore not entitled to have the Fund make any payments on its behalf. The Fund asserts that it was not aware of the noncompliance at the time but acted in reliance on St. Mary's representations that it was in compliance. In November 1997, the Milwaukee County Circuit Court ruled in favor of the Fund, and St. Mary's repaid the Fund $3,593,797 for previous claim payments, $1,409,075 for interest, and $12,771 for other costs, less $171,956 of assessment fees paid by St. Mary's and related interest.

10. Claim Annuities

The settlement of a claim may result in the purchase of an annuity. Under specific annuity arrangements, the Fund may have ultimate responsibility for annuity payments if the annuity company and the reassignment company default on annuity payments. One of the Fund's annuity providers defaulted on $76,025 in annuity payments through June 30, 2000, which the Fund subsequently paid. The annuity provider is currently making the majority of these annuity payments, but the Fund continues to make monthly annuity payments of $224 to cover defaulted payments. The Fund has received reimbursement for these payments, including interest, of $59,998 through June 30, 2000. It is unclear when the annuity provider will be able to make the remaining annuity payments and whether the Fund will be able to recover the remaining annuity payments made on the behalf of the annuity provider. The total estimated replacement value of the Fund's annuities as of June 30, 2000, 1999, and 1998, was $120.4 million, $119.8 million, and $115.2 million, respectively. The Fund reserves the right to pursue collection from state guarantee funds.

11. Pension Plan

Permanent full-time employees of the Fund are participants in the Wisconsin Retirement System (WRS), a cost-sharing, multiple-employer, defined benefit plan governed by Chapter 40 of Wisconsin Statutes. State and local government public employees are entitled to an annual formula retirement benefit based on: 1) the employee's final average earnings; 2) years of creditable service; and 3) a formula factor. If an employee's contributions, matching employer's contributions, and interest credited to the employee's account exceed the value of the formula benefit, the retirement benefit may instead be calculated as a money purchase benefit.

WRS is considered part of the State of Wisconsin's financial reporting entity. Copies of the separately issued financial report that includes financial statements and required supplementary information for the year ending December 31, 1999, may be obtained by writing to:

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

Generally, the State's policy is to fund retirement contributions on a level-percentage-of-payroll basis to meet normal and prior service costs of the WRS. Prior service costs are amortized over 40 years, beginning January 1, 1990. The retirement plan requires employee contributions equal to specified percentages of qualified earnings based on the employee's classification, plus employer contributions at a rate determined annually. The relative position of the Fund in the WRS is not available since WRS is a statewide, multiple-employer plan.

12. Retained Earnings

The Fund reported negative retained earnings as of June 30, 1998 of $22.2 million. However, as of June 30, 1999, the Fund reported positive retained earnings of $8.6 million, which increased to $27.2 million by June 30, 2000. The Fund's management and Board actively monitor the Fund's retained earnings balance, with the intent of keeping it as close to zero as possible.

13. Subsequent Events

On October 3, 2000, the 1st District Court of Appeals issued a decision in favor of Physicians Insurance Company of Wisconsin in a lawsuit brought against it by the Fund involving the interpretation of the responsibilities of other medical malpractice insurers under s. 655.27(5)(b), Wis. Stats. The Court of Appeals ruled that legal counsel retained by a medical malpractice insurer in an action to which ch. 655, Wis. Stats., applies is not required to assume an attorney-client relationship with the Fund. As a result of this decision, it is likely that the Fund

will now have to retain counsel on all claims filed against it. The Fund's actuaries estimate that the Fund may incur additional defense costs ranging from $4.0 million to $8.0 million per year if required to retain legal counsel for every reported claim.

There are currently over 40 cases in Wisconsin courts challenging the State's limit on non-economic damages in medical malpractice cases. In a July 1998 ruling from the Milwaukee County Circuit Court, the non-economic damages limit was found to be unconstitutional. This case was then accepted directly on appeal by the Wisconsin Supreme Court, without first going through the Court of Appeals. In May 2000, the Wisconsin Supreme Court deadlocked 3-3 on the constitutionality of the limit, with 1 justice abstaining. On December 19, 2000, the 1st District Court of Appeals, in a 2-1 vote, ruled the limit to be constitutional. According to the Fund's actuaries, if this limit were to be overturned and deemed retroactive to the effective date of May 25, 1995, the Fund's undiscounted unpaid claim liabilities could increase by as much as $125 million.

14. Prior-Period Adjustment

The Patients Compensation Fund implemented GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*, during the fiscal year ending June 30, 1998. This standard requires that governmental entities report investments at fair value in their balance sheets and include changes in fair value in investment income. The retained earnings balance for FY 1996-97 has been restated as follows:

Retained earnings on June 30, 1997, as previously reported	($44,094,214)
Increase of State Investment Fund shares, investments, and retained earnings resulting from implementation of GASB Statement No. 31	5,707,539
Retained earnings on June 30, 1997, as restated	($38,386,675)

15. Audit Adjustments

The financial statements presented in this report reflect audit adjustments made subsequent to the Commissioner of Insurance's annual reports to the Governor and Legislature, which include unaudited financial statements.

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Independent Auditor's Report on Compliance and on Internal Control Over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards

We have audited the financial statements of the Patients Compensation Fund as of and for the years ended June 30, 2000, 1999, and 1998 and have issued our report thereon dated May 18, 2001. We conducted our audit in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Compliance

As part of obtaining reasonable assurance about whether the Patients Compensation Fund's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, and contracts, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed instances of noncompliance that are required to be reported under *Government Auditing Standards*. Specifically, we noted the Patients Compensation Fund did not have adequate procedures in place to ensure that health care providers who have or had primary "claims-made" insurance maintained appropriate coverage. As a result, we found several instances in which the health care providers did not have the appropriate primary coverage required by statutes. We discuss this concern further in the report (01-11) section titled "Noncompliance with Primary Insurance Coverage Requirements." The Office of the Commissioner of Insurance has agreed to implement the recommended improvements.

Internal Control over Financial Reporting

In planning and performing our audit, we considered the Patients Compensation Fund's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the Fund's ability to record, process, summarize, and report financial data consistent with the assertions of management in the Fund's financial statements. Specifically, we identified several areas in which the Patients Compensation Fund needs to improve its security and access to the Fund's computerized data and system, which we discussed in interim correspondence with the Office of the Commissioner of Insurance. The Office of the Commissioner of Insurance has agreed to implement the recommended improvements.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, we believe that none of the reportable conditions described above is a material weakness.

This report is intended for the information of the Patients Compensation Fund, the Office of the Commissioner of Insurance, the Board of Governors, and the Wisconsin Legislature. This independent auditor's report, upon submission to the Joint Legislative Audit Committee, is a matter of public record and its distribution is not limited. However, because we do not express an opinion on compliance or provide assurance on internal control over financial reporting, this report is not intended to be used by anyone other than these specified parties.

LEGISLATIVE AUDIT BUREAU

May 18, 2001

by

Diann Allsen
Audit Director

Appendix 1

Annual Provider Assessments[1]

Provider Types	Fiscal Year 1997-98	1998-99[2]	1999-00	2000-01	2001-02
Physician Class 1[3]	$ 2,647	$ 2,721	$ 2,531	$ 1,898	$ 1,518
Physician Class 2[4]	5,294	5,170	4,809	3,606	2,885
Physician Class 3[5]	11,382	11,292	10,504	7,877	6,302
Physician Class 4[6]	15,882	16,326	15,186	11,388	9,110
Nurse Anesthetist	678	678	631	475	380
Hospital--per Occupied Bed	167	167	155	116	93
Nursing Home--per Occupied Bed	31	31	29	22	18
Employees of a Partnership or Corporation:					
Nurse Practitioner	662	680	631	475	380
Advanced Nurse Practitioner	926	952	886	664	531
Nurse Midwife	5,823	5,986	5,568	4,176	3,341
Advanced Nurse Midwife	6,088	6,258	5,821	4,365	3,492
Advanced Practice Nurse Prescriber	926	952	886	664	531
Chiropractor	1,059	1,088	1,012	759	607
Dentist	529	544	506	380	304
Oral Surgeon	3,971	4,082	3,797	2,847	2,278
Podiatrists--Surgical	11,250	11,564	10,757	8,067	6,454
Optometrist	529	544	506	380	304
Physician Assistant	529	544	506	380	304

[1] These rates apply to providers having Wisconsin as their primary place of practice. Other rates apply to providers for whom Wisconsin is not their primary place of practice.

[2] Overall, there was no change from FY 1997-98 rates. However, there were minor rate changes for certain provider types.

[3] Includes family or general practice physicians not performing surgery, and nutritionists.

[4] Includes family or general practice physicians performing minor surgery, and opthamologists performing surgery.

[5] Includes most types of surgeons, such as plastic, hand, general, and orthopedic.

[6] Includes obstetric and neurological surgeons.

Appendix 2

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott McCallum, Governor
Connie L. O'Connell, Commissioner

Wisconsin.gov

121 East Wilson Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: information@oci.state.wi.us
http://badger.state.wi.us/agencies/oci/oci_home.htm

May 23, 2001

Janice Mueller, State Auditor
Legislative Audit Bureau
22 E Mifflin St Ste 500
Madison WI 53703

Re: Response to the Audit Report of the Patients Compensation Fund

Dear Ms. Mueller:

Thank you for the opportunity to review and comment on the audit report of the Patients Compensation Fund. The following is our response to the findings.

Recommendation: "We recommend the Office of the Commissioner of Insurance contract for an audit of the actuarial methods and assumptions used in estimating claim liabilities and recommending assessment levels for the Patients Compensation Fund."

Response: We agree, and will contract with an actuarial firm to perform a regular audit of the assumptions and methodologies used by our current actuarial contractor.

Recommendation: "we recommend that Office of the Commissioner of Insurance appoint an actuary to the vacant insurance representative position on the Board of Governors and work with the Board to provide actuarial representation on the Actuarial and Underwriting Committee. Further, we recommend that membership on the Actuarial and Underwriting Committee be broadened to represent interest in addition to those of health care providers."

Response: We agree. The Office of the Commissioner of Insurance (OCI) is currently recruiting for an actuary to serve on both the Board and the Actuarial and Underwriting Committee. We will also work towards adding another actuarial or business professional to serve on the Actuarial committee to broaden the represented interests, as well as provide the needed expertise. OCI will work with the Board of Governors to develop membership guidelines for all of its primary committees.

Recommendation: "we recommend the Patients Compensation Fund take immediate steps to identify all providers that currently have insufficient coverage and follow up with providers and the Department of Regulation and Licensing to bring about compliance with state law. Further, we recommend Patients Compensation Fund staff develop and implement routine procedures to formally notify providers and the Department of Regulation and Licensing whenever a provider does not have sufficient primary coverage."

Response: Existing Fund procedures address notice to providers and necessary followup with the Department of Regulation and Licensing should a provider not have primary coverage in place for the current time period.

The Fund has developed and implemented new procedures to ensure that the proper steps are taken when it is determined that a provider is not in compliance with tail coverage requirements. These procedures include notifying the provider of the noncompliance, and then, if it is not resolved, a noncompliance letter will be sent to the Department of Regulation and Licensing. The new procedures implemented to address the tail coverage issue are similar to the current noncompliance procedures in place which are used to address other primary coverage gap issues. Fund staff is currently in the process of identifying all providers who are currently in noncompliance with the tail coverage requirement. Letters will be sent to the providers and then the Department of Regulation and Licensing will be notified if the provider does not come into compliance.

If you have any questions, or would like to discuss our response, please contact me at 266-7843.

Sincerely,

Eileen Mallow
Assistant Deputy Commissioner of Insurance

EM:tlw